U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7500
(202) 693-7365 (FAX)

In The Matter Of:

DAVID F. ENGLE

Claimant

v.

BETHENERGY MINES

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-In-Interest

DATE: November 17, 2000

Case No.: 2000-BLA-779

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* (the "Act"). The Act and implementing regulations, 20 C.F.R. parts 410, 718, 725 and 727 (the "Regulations"), provide compensation and other benefits to: (1) living coal miners who are totally disabled due to pneumoconiosis and their dependents; (2) surviving dependents of coal miners whose death was due to pneumoconiosis; and (3) surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death (for claims filed prior to January 1, 1982). In this case, the Claimant, David Engle, alleges that he is totally disabled due to pneumoconiosis.

The Act and Regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); *see* 20 C.F.R. § 718.201.

I conducted a hearing on this claim on October 5, 2000, in Pittsburgh, Pennsylvania. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure, 29 C.F.R. Part 18. At the hearing, Director's Exhibits 1-36 and Employer's Exhibits 1-13 were admitted into evidence without objection. Tr. at 5-6.[1]

In reaching my decision, I have reviewed and considered the entire record, including all exhibits, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Claimant filed his initial claim on February 13, 1991. The claim was denied by the Director of the Office of Workers' Compensation Programs (the "Director," "OWCP") on May 10, 1991, on the grounds that although the Claimant had established that he had pneumoconiosis, the evidence did not show that the Claimant's pneumoconiosis was caused by coal mine work, or that the Claimant was totally disabled. The Claimant did not appeal that determination. DX 34.

The Claimant filed his current claim on August 9, 1999. DX 1. The Director issued an informal denial on November 11, 1999. DX 18. When the Claimant appealed, the Director conducted an informal conference. The Director issued a Memorandum of Informal Conference denying benefits on February 24, 2000. DX 30. Although the 1991 claim resulted in a finding that the Claimant had pneumoconiosis, based on more recent medical evidence, the Director concluded in the current claim that he does not have pneumoconiosis. The Director also concluded that the evidence did not establish causation, total disability, or a material change in conditions. The Claimant appealed on March 1, 2000. DX 31. The claim was referred to the Office of Administrative Law Judges for hearing on May 26, 2000. DX 36. Because his current claim was filed after April 1, 1980, it is governed by the Regulations at 20 C.F.R. Part 718. Because it was filed more than one year after his previous claim was denied, it is also governed by the Regulation regarding duplicate claims, 20 C.F.R. § 725.309.

ISSUES

The issues contested by the Employer and the Director are:

1. Whether the evidence establishes a material change in conditions pursuant to 20 C.F.R. § 725.309.

2. Whether Mr. Engle has pneumoconiosis as defined by the Act and the Regulations.

3. Whether his pneumoconiosis arose out of coal mine employment.

4. Whether he is totally disabled.

---

[1] The following abbreviations are used for reference within this opinion: DX, Director's Exhibits; EX, Employer's Exhibits; TR, Hearing Transcript; Dep., Deposition.

5. Whether his total disability is due to pneumoconiosis.

DX 35; Employer's Hearing Report.

APPLICABLE STANDARD

Pursuant to 20 C.F.R. § 725.309, in order to establish that he is entitled to benefits, Mr. Engle must demonstrate that there has been a "material change in conditions" since the denial of his previous claim such that he now meets the requirements for entitlement to benefits under 20 C.F.R. Part 718. In order to establish entitlement to benefits under Part 718, Mr. Engle must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.204. I must consider the new evidence and determine whether Mr. Engle has proved at least one of the elements of entitlement previously decided against him. If so, then I must consider whether all of the evidence establishes that he is entitled to benefits. *Labelle Processing Company v. Swarrow*, 72 F.3d 308 (3rd Cir. 1996); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

David Engle was born on December 10, 1941, DX 1, and is currently 58 years old. He has been married to his wife, Gladys, since January 6, 1961. DX 9. He began working in the mines in 1966. Tr. at 10. He worked for the Employer, BethEnergy Mines, Inc., from May 1974 to September 1977 as a laborer, assistant foreman and section foreman. Tr. at 9-11; DX 34. He testified that he had some shortness of breath when he was working in the mines; one time he passed out. Tr. at 11. He stopped working in the mines because a man was killed under his supervision, and he thought he did not have enough education to keep up with his job. Tr. at 29-30. The parties stipulated and I find that Mr. Engle worked at least 12 years as a miner. His last coal mine employment was in Pennsylvania. DX 34. Therefore this claim is governed by the law of the Third Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc). From 1978 to 1991, he was self-employed as an auto mechanic. From 1991 to 1999, he worked repairing equipment for a butcher supply company. Tr. at 12, 25-26; DX 4. He was hospitalized several times the last year he worked, and finally stopped working because he "couldn't make it" any more because of his breathing problems. Tr. at 12-13; 15. He is currently under treatment by a pulmonary specialist. Tr. at 16-18. He said he smoked for about 40 years, but never over one pack per day, and sometimes much less. Tr. at 19-20.

Material Change in Conditions

In a duplicate claim, the threshold issue is whether there has been a material change in conditions since the previous claim was denied. Mr. Engle's initial claim was filed and denied in 1991. According to his testimony, he stopped working altogether in 1999 because of breathing problems. As will be discussed in more detail below, pulmonary function tests and medical reports indicate that Mr. Engle now has a pulmonary impairment which is totally disabling. Thus I find that Mr. Engle has established that a material change in conditions has occurred. It follows that I must consider all of the evidence in the record in reaching my decision whether he is now entitled to benefits.

Medical Evidence

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

20 C.F.R. § 718.201. This definition of pneumoconiosis ("legal pneumoconiosis") encompasses many more diseases than does a clinical diagnosis of coal workers' pneumoconiosis ("medical pneumoconiosis"). *See Barber v. Director, OWCP,* 43 F. 3d 899, 901 (4th Cir. 1995); *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821-822 (4th Cir. 1995); *Kline v. Director, OWCP,* 877 F.2d. 1175, 1178-1179 (3rd Cir. 1989). In this case, Mr. Engle's medical records indicate that he has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. *Richardson v. Director, OWCP,* 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

20 C.F.R. § 718.202(a) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in

§§ 718.304,[2] 718.305[3] or 718.306,[4] or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Mr. Engle has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, Mr. Engle has less than 15 years of work in coal mines, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions.

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Small opacities (1, 2, or 3) may classified as round (p, q, r) or irregular (s, t, u). The following table summarizes the x-ray findings available in this case.[5]

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 28	12/10/99 01/19/00	Fino B, BCI, BCP	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.

[2]Irrebuttable presumption of total disability or death due to pneumoconiosis if there is a diagnosis of chronic dust disease of the lung based on x-rays showing one or more large opacities, biopsy or autopsy showing massive lesions, or diagnosis in accord with acceptable medical procedures of a condition which could reasonably be expected to yield the same results ("complicated pneumoconiosis").

[3]Rebuttable presumption of total disability due to pneumoconiosis for a miner employed for 15 or more years with negative x-rays but other evidence of a totally disabling respiratory or pulmonary impairment.

[4]Applicable only to deceased miners.

[5]Qualifications of physicians are abbreviated as follows: A= A-reader; B= B-reader; BCR= Board-Certified Radiologist; BCP=Board-Certified Pulmonologist; BCI= Board-Certified Internal Medicine. Readers who are Board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

Film Quality: Codes are 1, Good; 2, Acceptable, with no technical defect likely to impair classification of the radiograph for pneumoconiosis; 3, Poor, with some technical defect but still acceptable for classification purposes; and 4, Unacceptable.

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
DX 32	09/29/99 01/08/00	Castro			Pulmonary interstitial changes bilaterally, similar to prior [08/01/99] exam.
EX 10	09/02/99 09/20/00	Spitz B			Film completely negative. No evidence of coal worker's pneumoconiosis
EX 9	09/02/99 09/09/99	Wiot B, BCR	1		Film completely negative. No evidence of coal worker's pneumoconiosis. Chest within normal limits.
DX 28	09/02/99 01/19/00	Fino B, BCI, BCP	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.
DX 17	09/02/99 11/03/99	Gaziano B, BCI, BCP	1	1/1 t/t	Parenchymal abnormalities consistent with pneumoconiosis
DX 16	09/02/99 10/18/99	Navani B, BCR	3		Film completely negative.
DX 15	09/02/99 09/07/99	Thomeier B, BCR	1	1/0 s/t	Mild mid and lower lung field interstitial changes which could be consistent with pneumoconiosis
DX 32	08/01/99 08/03/99	Wildenhain			Interstitial fibrotic changes without evidence of infiltrate.
DX 32	07/31/99 08/02/99	George			There are severe chronic interstitial fibrotic changes seen. The upper lobes are emphysematous.
DX 28	02/21/99 01/19/00	Fino B, BCI, BCP	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.
DX 32	02/21/99 02/21/99	Kirshen			Diaphragm is flattened and the lungs are hyperexpanded consistent with emphysema. Chronic interstitial lung changes are present in both lung bases.
EX 1	01/20/99 01/19/00	Fino B, BCI, BCP	2		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.
DX 32	01/20/99 01/20/99	Behun			Ephysematous appearing chest which is otherwise unremarkable.

Exhibit Number	Date of X-ray/ Date Read	Reading Physician Name and Qualifications	Film Quality	ILO-U/C Class.	Interpretation or Impression
EX 7	06/11/91 09/05/00	Perme B	2		Name of patient not on film. No parenchymal or pleural abnormalities consistent with pneumoconiosis. Findings consistent with emphysema
EX 5	06/11/91 08/29/00	Wiot B, BCR	2		Name of patient not on film. Film completely negative. No evidence of coal worker's pneumoconiosis.
EX 10	02/27/91 09/20/00	Spitz B, BCR	1		Film completely negative. No evidence of coal worker's pneumoconiosis.
EX 9	02/27/91 09/09/00	Wiot B, BCR	1		Film completely negative. No evidence of coal worker's pneumoconiosis. Chest within normal limits.
DX 28	02/27/91 01/19/00	Fino B, BCI, BCP	3		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.
DX 34	02/27/91 03/01/91	Yarussi B	1	1/0 t/t	Interstitial nodularity throughout the lower two-thirds of both lungs is consistent with pneumoconiosis. No pleural scarring is noted. There is some pleural thickening within the right minor fissure.
DX 28	11/13/89 01/19/00	Fino B, BCI, BCP	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.
EX 3	11/13/89 11/13/89	McMahon B		0/0	No significant pulmonary or pleural abnormalities.
DX 28	11/04/88 01/19/00	Fino B, BCI, BCP	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.
EX 1	11/04/88 11/07/88	Behun B, BCR		0/0	Lungs clear. No indication of inhalatory disorder and no pleural abnormalities. Essentially normal chest.
DX 28	12/28/87 01/19/00	Fino B, BCI, BCP	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.
DX 28	12/03/86 01/19/00	Fino B, BCI, BCP	1		No parenchymal or pleural abnormalities consistent with pneumoconiosis. Emphysema.

Medical Opinions

Treatment Records

The file contains Mr. Engle's treatment records from The Washington Hospital between January 17, 1999, and January 17, 2000. DX 27, DX 29 and DX 32. His primary doctors have been Dr. Jenee Bowman, a pulmonary specialist who has been treating him for the past year, Tr. at 16, and Dr. Craig D. Fox, his family doctor for the past ten years, Tr. at 28.

Mr. Engle was admitted to the hospital for pneumonia from January 17 to 21, 1999. Discharge diagnoses were pneumonia, emphysema, non-insulin dependent diabetes mellitus, and arteriosclerotic heart disease.

He was again admitted to the hospital for recurrent pneumonia, chronic obstructive pulmonary disease ("COPD"), and hypertension from February 19 to February 23, 1999. Dr. Fox related his COPD to his being "a long term smoker."

He was admitted for an exacerbation of COPD, acute bronchitis and arteriosclerotic heart disease from July 26, 1999, to August 3, 1999. Cardiac catheterization performed August 2, 1999, showed normal left ventricular function and single vessel coronary artery disease; medical treatment was recommended for his heart.

The results of several chest x-rays, and a pulmonary function test administered on August 17, 1999, are reported on the charts above and below. An oxygen prescription study was also performed on August 17. Dr. Bowman's notes indicate that Mr. Engle was complaining of shortness of breath on exertion, and that he was still smoking. Mr. Engle walked on a treadmill for 6 minutes at 1.5-2.0 miles per hour. His oxygen saturations remained at 100% on room air. Dr. Bowman concluded that he did not need supplemental oxygen.

Dr. John Wilson saw the Claimant in follow-up of his catheterization on October 20, 1999. He said it was hard to know how much of the Claimant's shortness of breath was related to his heart, but increased his Cardizem dosage.

He was again admitted to the hospital from November 27 to December 3, 1999, due to an exacerbation of his COPD and acute bronchitis. CT of the chest using a high resolution protocol designed to evaluate for interstitial lung disease taken on November 29, 1999, showed scattered fibrotic and emphysematous changes, multiple nonspecific mediastinal lymph nodes, and a few slightly more prominent scattered focal densities throughout the lungs, too small to definitely characterize, which could be fibrotic changes or prominent vessels, or punctate densities of other etiology.

Some of the notes and reports refer to Mr. Engle's history of working in the mines and reported history of black lung, and many mention that he is a smoker, but none of his treating doctors have offered any opinion as to the cause of his interstitial lung disease. In a report

relating to his January 1999 hospital admission, Dr. Bowman stated:

> He smokes now ½ pack of cigarettes per day but smoked prior 1 to 1-1/2 packs of cigarettes per day for the past 40+ years. He also worked in the coal mines in the past and was told he had "black lung". He had routine evaluations at the Centerville Clinic including pulmonary function testing and chest x-ray, however, his is not aware of the details. He was also told he has emphysema. He has not required any chronic lung medicines.

Her impressions were broncho spasm, history of coal workers' pneumoconiosis, rule out obstructive sleep apnea, heavy active smoker, history of coronary artery disease, history of hypertension. She made a similar entry in her report regarding his February 1999 hospital admission. In a report dictated July 30,1999, Dr. Bowman listed coal worker's pneumoconiosis as a diagnosis. In a report dictated November 28, 1999, however, Dr. Bowman listed "Interstitial lung disease/question coal worker's pneumoconiosis" as the fourth diagnosis after acute broncho spasm, COPD exacerbation, and acute bronchitis, rule-out pneumonia.[6] DX 27. As of January 17, 2000, Dr. Bowman's diagnoses (contained in her handwritten notes) included only chronic obstructive pulmonary disease, coronary artery disease and chronic dyspnea. DX 32.

Dr. Gregory J. Fino

Dr. Fino examined Mr. Engle on behalf of the Employer on December 10, 1999, and January 13, 2000. DX 28. Mr. Engle reported a history of working 12 years as a coal miner until 1978. All of his mining work was underground. His last job in the mines was as a foreman, involving no heavy work. After leaving the mines, he had his own auto repair business and repaired equipment at a butcher's shop. He retired from all work in July 1999 due to shortness of breath. He said he had had shortness of breath and pressure in the chest since 1966, which was getting worse. He had had double pneumonia four times in 1999, heart disease since 1989, and recently his blood sugar had become high due to steroid treatment for pneumonia. His prescriptions included Prednisone, Imdur, Cardizem, Glucophage, Glucotrol, Albuterol pump, Flovent, Serevent and Albuterol inhaler. On physical examination he had decreased breath sounds with wheezing and rhonchi on exhalation. In addition to conducting the examination, Dr. Fino reviewed many of Mr. Engle's medical records which are listed in the report. Some of the records seen by Dr. Fino have not been made exhibits and hence are not available to me. Results of chest x-ray readings and pulmonary function tests are reported on the charts above and below. Dr. Fino diagnosed chronic obstructive lung disease characterized by chronic obstructive bronchitis, broncho spasm and emphysema due to smoking. He concluded that Mr. Engle does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure. He based his conclusion on negative x-rays; spirometric evaluations showing obstructive ventilatory abnormality in the absence of any interstitial abnormality, and proportionally greater reduction in small airway flow than large airway flow, which he said was not consistent with coal dust related conditions; improvement of lung function following administration of bronchodilator, suggesting a non-fixed obstruction, again not consistent with pneumoconiosis; and the fact that total lung capacity was not reduced, ruling out restrictive lung disease and significant pulmonary fibrosis.

[6] One consultation note dated July 30, 1999, which included "COPD/black lung" as a diagnosis, was dictated by a nurse practitioner. DX 29.

Dr. Fino went on to state that Mr. Engle is unable to perform the requirements of his last job from a respiratory standpoint, but said even if he assumed that Mr. Engle has pneumoconiosis, "it has not contributed to his disability. He would be as disabled had he never stepped foot in the mines." Dr. Fino included a lengthy review of medical literature and studies in his report, explaining his view that the effects of smoking can be distinguished from the effects of coal dust inhalation, and his reasons for rejecting coal dust exposure as the reason for Mr. Engle's pulmonary impairment.

Dr. Fino was deposed on September 25, 2000. EX 13. He is board certified in Internal Medicine and Pulmonary diseases, and treats individuals with pulmonary disease. Dep. at 3. He is certified as a B-reader. Dep. at 4. In his deposition testimony, Dr. Fino emphasized that Mr. Engle had normal lung function until 1991, up to fourteen years after he left coal mining, leading Dr. Fino to conclude that the deterioration in function after 1991 was due to smoking rather than coal dust exposure. Dep. at 22-23. He reiterated his conclusion that Mr. Engle does not have either medical or legal pneumoconiosis. Dep. at 24-25. He also testified that the irregular opacities identified by Dr. Gaziano in 1999 are not opacities consistent with pneumoconiosis, which are round. Dep. at 33-34. Finally, he also testified that absent low oxygen blood gas levels, category one pneumoconiosis generally does not cause an impairment, stating, "The typical ventilatory impairment one sees ... is when there is lots of pneumoconiosis, category three or greater, and you see obstruction with restriction." Mr. Engle's pattern he characterized as "pure obstruction." Dep at 35-36.

Dr. Stephen J. Basheda

Dr. Basheda examined Mr. Engle on behalf of the Director on September 16, 1999. Mr. Engle reported a history of working 12 years in coal mining. He said he had also worked as an auto repair mechanic and a service technician for a butcher supply company. He reported three attacks of pneumonia in 1999, and constant wheezing. He was uncertain whether he had bronchial asthma. He also reported a history of heart disease and high blood pressure. He reported symptoms of wheezing, shortness of breath, and chest pain. He was taking Cardizem, ASA, Imdur, Albuterol, Flovent, and possibly Atrovent. Results of pulmonary function tests and blood gas study conducted by Dr. Basheda are reported on the charts below. Dr. Basheda diagnosed high blood pressure, COPD/Asthma, and coronary artery disease. He concluded that the claimant had severe limitation on his activity due to dyspnea attributable to smoking. He saw no evidence of coal worker's pneumoconiosis.

Dr. David A. Celko

Dr. Celko examined Mr. Engle on behalf of the Director on March 15, 1991. Mr. Engle reported that he had worked for 12 years as a miner. He had also worked three years as a driver for an ambulance and chair company, and ten years as a self-employed mechanic doing automobile repair. He reported daily attacks of wheezing since 1985, and said that he had been diagnosed with coronary artery disease in 1990. He had undergone cardiac catheterization. He was a current smoker, having started in 1955, smoking ½ pack of filtered cigarettes per day. His symptoms included dyspnea for five years, a daily cough for five to seven years, recent onset hemoptysis for about a month, and exertional chest pain relieved by rest. He was taking Cardizem and a second (name illegible) medication. Results of pulmonary function studies and arterial blood gas study Dr. Celko conducted are reported in the charts below. Dr. Celko diagnosed category 1 coal

workers' pneumoconiosis, coronary artery disease, hypertension and hemoptysis. He concluded that Mr. Engle was disabled from a cardiac standpoint, but had no significant respiratory impairment. DX 34.

Discussion of the Evidence Relating to the Existence of Pneumoconiosis

Pneumoconiosis is a progressive and irreversible disease. As a general rule, therefore, more weight is given to the most recent evidence. *See Mullins Coal Co. of Virginia v. Director, OWCP*, 483 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); Stanford *v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993); *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

Of the 13 available x-rays in this case, two have been read by some but not all reviewers to be positive for pneumoconiosis, and eight to be negative. For cases with conflicting x-ray evidence, the Regulations specifically provide,

> Where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays.

20 C.F.R. § 718.202(a)(1); *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31, 1-37 (1991). Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985). A judge may consider the number of interpretations on each side of the issue, but not to the exclusion of a qualitative evaluation of the x-rays and their readers. *Woodward*, 991 F.2d at 321.

X-rays taken on September 29, 1999, August 1, 1999, and July 31, 1999, were taken in connection with Mr. Engle's hospital stays and have not been classified in accordance with ILO-U/C Classification standards. Each was interpreted to show bilateral interstitial fibrotic changes, as were some of the others listed below, but none of the interpreters or treating physicians have indicated the etiology of those changes. In any event, they cannot be used as the basis for a finding of pneumoconiosis because they have not been classified in accordance with the Regulations. 20 C.F.R. §§ 718.102 and 202.

An x-ray taken on December 10, 1999, has only been read by Dr. Fino, who is a B-reader. He read the x-ray to show no abnormalities consistent with pneumoconiosis. It must be taken as negative.

An x-ray taken on September 2, 1999, has been read by six physicians. Four (Spitz, Wiot,

Fino and Navani) found it negative. Of those four, two are board certified radiologists and B-readers (Wiot and Navani) and two are B-readers only (Spitz and Fino). Two physicians found it positive, one a board certified radiologist and B-reader (Thomeier), and one a B-reader (Gaziano). Thomeier read it as 1/0; Gaziano read it as 1/1. Taking the number and qualifications of the readers into account, as well as the 1/0 classification by the better qualified of the two readers who found it positive, I find this x-ray to be negative.

An x-ray taken February 21, 1999, has been read by Dr. Fino, a B-reader, and Dr. Kirshen, qualifications unknown. This was another x-ray taken in connection with Mr. Engle's hospital treatment. Dr. Fino read it as negative for pneumoconiosis, and it must be so found.

An x-ray taken on January 20, 1999, has been read by Dr. Fino, a B-reader, and Dr. Behun, qualifications unknown. This was another x-ray taken in connection with Mr. Engle's hospital treatment. Dr. Fino read it as negative for pneumoconiosis, and it must be so found.

An x-ray taken on June 11, 1991, has been read by two physicians, one a board-certified radiologist and B-reader (Wiot), and one a B-reader (Perme). Both found it negative. Both also commented that the name of the patient was not on the film. For this reason I have given it little weight.

An x-ray taken on February 27, 1991, has been read by four doctors. Three, including two board-certified radiologists and B-readers (Spitz and Wiot), and one B-reader (Fino) found it negative. One B-reader (Yarussi) classified it as 1/0. Based on the better qualifications of the readers, I find this x-ray to be negative.

X-rays taken on November 13, 1989, November 4, 1988, December 28, 1987, and December 3, 1986, have all been read as negative by Fino, and the later two were also read as negative by a B-reader (McMahon) and a board-certified radiologist (Behun) as well. No physician has read these x-rays as positive. I also find these x-rays to be negative.

These constitute all the x-rays in the record. I have found all of them to be negative. Mr. Engle cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

Next I must consider the medical opinions. Only one physician who examined Mr. Engle, Dr. Celko, has given a definitive diagnosis of pneumoconiosis, and that was nine years ago. Neither of the other physicians who examined Mr. Engle on behalf of the Director (Dr. Basheda) or the Employer (Dr. Fino) have diagnosed the him with coal workers' pneumoconiosis, or any other pulmonary or respiratory illness related to chronic dust disease arising out of coal mine employment. Dr. Fino and Dr. Basheda, who examined Mr. Engle in 1999 and 2000, concluded that he has a severe impairment as a result of smoking. Dr. Celko, who examined him in 1991, found no significant respiratory impairment, despite the diagnosis of pneumoconiosis. Furthermore, although Mr. Engle has reported to his current doctors that he received a diagnosis of black lung in the past, none of his treating physicians have confirmed the diagnosis. Although none have addressed the issue very explicitly, it appears that they attribute his COPD to smoking, and have not given any opinion as to the etiology of his interstitial fibrotic changes. Dr. Bowman's most recent notes and reports either do not refer to black lung at all, or refer to it as a

"questionable" diagnosis. In view of the progressive and irreversible nature of pneumoconiosis, I conclude that Dr. Celko was in error when he made the diagnosis. Thus I find that the medical opinions do not support a conclusion that Mr. Engle has pneumoconiosis within the meaning of the Act and Regulations.

Because the evidence does not establish the existence of pneumoconiosis by means of x-rays or reasoned medical opinion, or by any other means provided by the Regulations, I find that Mr. Engle has failed to meet his burden of establishing that he has pneumoconiosis.

Causal Relationship between Pneumoconiosis and Coal Mine Employment

The Regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 20 C.F.R. § 718.203(b). Mr. Engle was employed as a miner for at least 12 years, and would therefore be entitled to the presumption. Because I have concluded that the evidence does not establish that Mr. Engle has pneumoconiosis, however, this issue is moot.

Total Disability

As noted above, the Third Circuit standard for review of a duplicate claim requires that the entire record be considered if a claimant establishes one of the elements of entitlement previously decided against him. Although I have ultimately decided that the evidence as a whole does not establish that Mr. Engle has pneumoconiosis, I have reviewed the entire record, rather than just the new evidence, because the new evidence does establish that he is totally disabled by a pulmonary impairment. A miner is considered totally disabled if he has complicated pneumoconiosis, 20 C.F.R. § 304, or if pneumoconiosis prevents him from doing his usual coal mine employment or comparable and gainful employment, 20 C.F.R. § 204(b). The Regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b). In a living miner's claim, however, lay testimony "is not sufficient, in and of itself, to establish total disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 106 (1994). There is no evidence in the record that Mr. Engle suffers from complicated pneumoconiosis or cor pulmonale.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). The following chart summarizes the results of the pulmonary function studies available in this case. "Pre-" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. The quality standards for pulmonary function studies are found at 20 C.F.R. § 718.103. The standards require that the studies be accompanied by two or three tracings of each

test performed. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. The file contains the following pulmonary function studies:

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	Tra- cings	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 28 12/10/99 Fino	58 71"	1.92 2.22	77 89	3.71 4.07	Yes	Not recorded/ Good	Yes FEV_1 MVV	Moderate obstruction with a bronchodilator response. Total lung capacity normal and air trapping is present. Reduced diffusing capacity.
DX 11 09/16/99 Basheda	57 71"	2.65	73	4.33	Yes	Good/ Good	No	Mild obstruction
DX 32 08/17/99 Bowman	57 73"[7]	2.71 2.82	85 71	3.98 3.95	Yes	Not recorded Very good	No	Moderate obstructive ventilatory defect without bronchodilator response. Diffusion capacity is mildly reduced.

[7]The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Easter Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance of 2" in the recorded height of the miner, I have taken the average height (72") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	MVV Pre-/ Post	FVC Pre-/ Post	Tra- cings	Compre- hension/ Cooper- ation	Qual- ify	Physician Impression
DX 32 01/21/99 Bowman	57 73"	2.07 1.84	76[8] 86	3.5 3.71	No	Not recorded/ Improved effort during post test	Yes FEV_1 MVV	Productive cough for yellow sputum throughout testing. Moderately severe obstructive ventilatory defect nonresponsive to bronchodilators. Diffusing capacity severely reduced but normal when corrected for alveolar volume.
DX 34 02/27/91 Celko	49 71"	3.32	86	4.96	Yes	Good Good	No	Results within guidelines for bronchodilator prescription, but was not given. Very mild obstructive ventilatory pattern. Small airways disease.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled. The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable table values set forth in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). The file contains the following blood gas studies:

[8]Both MVV values in this test were marked "outside 95% confidence interval."

Exhibit Number	Date	Physician	pCO_2 at rest exercise	pO_2 at rest exercise	Qualify	Physician Impression
DX 28	01/13/00	Fino	37	65	No	
DX 13	09/16/99	Basheda	37	67	No	Exercise study contraindicated due to coronary artery disease, acute broncho spasm
DX 34	02/27/91	Celko	37	64	No	Exercise study not done due to history of coronary artery disease. Mild hypoxemia.

Discussion of the Evidence Relating to Total Disability

Although none of the blood gas studies have resulted in qualifying values based on a respiratory impairment, two of the pulmonary function studies have resulted in qualifying values because of reduced FEV_1 and MVV values based on obstructive lung disease. In addition, Dr. Fino opined that Mr. Engle is totally disabled as a result of his COPD. DX 28. This opinion is consistent with Mr. Engle's treatment records showing repeated hospitalizations in 1999 relating to his pulmonary disease. Finally, it is also consistent with Mr. Engle's testimony that he had to stop working because of breathing problems. I find that Mr. Engle is totally disabled by a pulmonary impairment.

Causation of Total Disability

In order to be entitled to benefits, Mr. Engle must establish that pneumoconiosis is a "substantial contributor" to his disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734 (3rd Cir. 1989). As I have found that the evidence does not establish that Mr. Engle has pneumoconiosis, he cannot establish that pneumoconiosis is a substantial contributor to his disability.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the claimant has failed to meet his burden to establish that he has pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers'

Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits under the Black Lung Benefits Act filed by David Engle on May 8, 1999, is hereby DENIED.

_____

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this (order of dismissal/decision and order) may appeal it to the Benefits Review Board within 30 days from the date of this (order of dismissal/decision and order), by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 22013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., N.W., Washington, D.C. 20210